U.S. Department of Labor

Office of Administrative Law Judges
800 K Street, NW, Suite 400-N
Washington, DC 20001-8002

(202) 693-7300
(202) 693-7365 (FAX)

Issue Date: 22 December 2003

In the Matter of:

RALPH BACK,
Claimant

Case No.: 2003-BLA-5321

v.

ARCH ON THE NORTH FORK, INC.,
Employer

and

ARCH COAL, INC.,
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

John Hunt Morgan, Esq.
Edmond Collett, PSC
Hyden, Kentucky
For the Claimant

Denise M. Davidson, Esq.
Barrett, Haynes, May, Carter & Roark
Hazard, Kentucky
For the Employer

Before: Alice M. Craft
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 et seq. The Act and implementing regulations, 20 CFR Parts 410, 718, 725 and 727, provide compensation and other benefits to living coal miners who are totally disabled due

to pneumoconiosis and their dependents, and surviving dependents of coal miners whose death was due to pneumoconiosis. The Act and regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. § 902(b); 20 CFR § 718.201 (2003). In this case, the Claimant, Ralph Back, alleges that he is totally disabled by pneumoconiosis.

I conducted a hearing on this claim on July 29, 2003, in Hazard, Kentucky. All parties were afforded a full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure before the Office of Administrative Law Judges, 29 CFR Part 18. At the hearing, Director's Exhibits ("DX") 1-33 and Employer's Exhibits ("EX") 1-3 were admitted into evidence without objection. Transcript ("Tr.") at 7-8.

In reaching my decision, I have reviewed and considered the entire record pertaining to the claim before me, including all exhibits, the testimony at hearing and the arguments of the parties.

PROCEDURAL HISTORY

The Claimant filed his claim on June 7, 2001. DX 2. The claim was denied by the District Director, Office of Workers' Compensation Programs ("OWCP") on September 16, 2002, DX 26, and on September 23, 2002, the Claimant filed a timely request for a hearing, DX 27. This claim was referred to the Office of Administrative Law Judges for hearing on January 7, 2003. DX 32.

APPLICABLE STANDARDS

This claim was filed after March 31, 1980, and after January 19, 2001, the effective date of the current regulations. For this reason, the current regulations at 20 CFR Parts 718 and 725 apply. 20 CFR §§ 718.2 and 725.2 (2003). In order to establish entitlement to benefits under Part 718, the Claimant must establish that he suffers from pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and that his pneumoconiosis is totally disabling. 20 CFR §§ 718.1, 718.202, 718.203 and 718.204 (2003).

ISSUES

The issues contested by the Employer and the Director are:

1. Whether Mr. Back has pneumoconiosis as defined by the Act and the Regulations.

2. Whether his pneumoconiosis arose out of coal mine employment.

3. Whether he is totally disabled.

4. Whether his disability is due to pneumoconiosis.

DX 32; DX 33; Tr. 6, 18.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and the Claimant's Testimony

The Claimant, Ralph Back, was deposed on January 2, 202, DX 17, and testified at the hearing. His testimony was similar on both occasions. He was born in 1952 and has a tenth grade education. DX 2; Tr. 10. His wife, whom he married in 1992, and his son, born in 1988, are his two dependents for purposes of possible augmentation of benefits. DX 9, DX10, Tr. 10. The Claimant testified that his physician is Dr. Robert Hoskins and that he sees him every month and a half. He uses an inhaler prescribed by Dr. Hoskins. Tr. 13. He uses it more in hot or cold, damp weather. He doesn't have a lot of breath for walking up hills. Tr. at 14. The Claimant used to smoke cigarettes at the rate of less than a pack per day, having smoked for ten years. He quit smoking twenty years ago. Tr. 15. He has a cough and sleeps on two pillows. He has been receiving Social Security disability benefits for ten years, based on a back injury. He believes he is totally and permanently disabled for any type of employment. Tr. 16, 18.

The Claimant testified that he has over 18 years of coal mine employment, all in surface mines. Tr. 11. The Employer stipulated to 18 years. Tr. 6. He worked for Arch on the North Fork, Inc. for 16 ½ of those years. Tr. 11. Although he worked for other coal mine companies after he last worked for Arch on the North Fork, Inc., none of that employment lasted for a year. Tr. 12. He was a heavy equipment operator, operating a loader, drill, bulldozer, rock truck, shovel, and anything available that he could operate. He operated an end loader, loading coal from the pit into trucks, more than any other equipment. Tr. 12. It was dusty, as he worked before cabs were required to be air conditioned. Tr. 13. He last worked as a coal miner in 1993, when he ceased working due to a back injury. Tr. 17.

The Claimant received a state workers' compensation award for retraining incentive benefits in 1991 after he was diagnosed with pneumoconiosis. DX 8. He was also deposed in connection with that claim, on January 22, 1992, DX 12. At the time he was deposed, he had been laid off from the mines, but he thought he could do that work again if he found employment. In fact he did return to the mines until he injured his back.

Mr. Back's last coal mine employment was in the state of Kentucky. DX 3, DX 5, Tr. 6. Therefore this claim is governed by the law of the Sixth Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (en banc).

Medical Evidence

Chest X-rays

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The following table summarizes the x-ray findings available in this case. The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis." A chest x-ray

classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 CFR § 718.102(b) (2003). All such readings are therefore included in the "negative" column. X-ray interpretations which make no reference to pneumoconiosis, positive or negative, generally given in connection with medical treatment for other conditions, are listed in the "silent" column.

Physicians' qualifications appear after their names. Qualifications have been obtained where shown in the record by curriculum vitae or other representations, or if not in the record, by judicial notice of the List of A and B-Readers issued by the National Institute of Occupational Safety and Health (NIOSH). If no qualifications are noted for any of the following physicians, it means that I have been unable to ascertain them either from the record or the NIOSH list. Qualifications of physicians are abbreviated as follows: B= NIOSH certified B-reader; BCR= board-certified in radiology. Readers who are board-certified radiologists and/or B-readers are classified as the most qualified. See *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B-readers need not be radiologists.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
10/04/90	DX 12 Myers 1/0 Lane (B) 1/0 Anderson 1/2		DX 12 Shotwell "Old granulomatous disease."
09/10/91	DX 12 Anderson 1/2	DX 12 Harrison (B)	
07/18/01		DX 13 Wicker (B) EX 1 Wiot (B, BCR)	DX 14 Sargent (B, BCR) Read for quality only Quality good.
08/23/01		DX 19 Lockey (B) DX 15, 18 Wiot (B, BCR)	
11/28/01	DX 16 Baker (B) 1/0		

Pulmonary Function Studies

Pulmonary function studies are tests performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. The greater the resistance to the flow of air, the more severe the lung impairment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV). The following chart summarizes the results of the pulmonary function studies available in this case. Bronchodilators were not administered in any of Mr. Back's tests. In a "qualifying" pulmonary study, the FEV_1 must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less. 20 CFR § 718.203(b)(2)(i) (2003).

Ex. No. Date Physician	Age Height	FEV_1	FVC	FEV_1/ FVC	MVV	Qualify?	Physician Impression
DX 12 09/10/91 Anderson	39 73.5"	4.97	5.95	83.5%	162	No	0% impairment
DX 13 07/18/01 Wicker	49 74"[1]	3.67	5.02	73%	81	No	
DX 19 08/23/01 Lockey	49 74"	4.67	6.23	74.9%		No	Normal.
DX 16 11/28/01 Baker	49 74"	4.44	6.11	72.6%	138	No	Normal

Arterial Blood Gas Studies

Blood gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The blood sample is analyzed for the percentage of oxygen (PO_2) and the percentage of carbon dioxide (PCO_2) in the blood. A lower level of oxygen (O_2) compared to carbon dioxide (CO_2) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled. The following chart summarizes the arterial blood gas studies available in this case. A "qualifying" arterial gas study yields values which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests with only one figure represent studies at rest only. Exercise studies are not required if medically contraindicated. 20 CFR § 718.105(b) (2003).

Exhibit Number	Date	Physician	PCO_2 at rest/ exercise	PO_2 at rest/ exercise	Qualify?	Physician Impression
DX 13	07/18/01	Wicker	35.8 39.0	71.0 82.5	No	
DX 19	08/23/01	Lockey	35	78	No	Normal.
DX 16	11/28/01	Baker	36	75	No	Mild resting arterial hypoxemia.

[1] The fact-finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221, 1-223 (1983); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109, 114, 116 (4th Cir. 1995). As there is a variance in the recorded height of the miner, I have taken the average height (73.8") in determining whether the studies qualify to show disability under the regulations. None of the tests are qualifying to show disability whether considering the average height, or the heights listed by the persons who administered the testing.

Medical Opinions

Medical opinions are relevant to the issues of whether the miner has pneumoconiosis, whether the miner is totally disabled, and whether pneumoconiosis caused the miner's disability. A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. 20 CFR §§ 718.202(a)(4) (2003). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 CFR § 718.202(a)(4) (2003). Where total disability cannot be established by pulmonary function tests, arterial blood gas studies, or cor pulmonale with right-sided heart failure, or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. 20 CFR § 718.204(b)(2)(iv) (2003). With certain specified exceptions, the cause or causes of total disability must be established by means of a physician's documented and reasoned report. 20 CFR § 718.204(c)(2) (2003). The record contains the following medical opinions relating to this case.

Dr. Anderson

Dr. William H. Anderson examined the Claimant on September 10, 1991, in connection with his state workers' compensation claim. DX 12. Dr. Anderson's examination included the taking of a chest x-ray, pulmonary function test and histories. A smoking history of between one-third and one-half of a pack of cigarettes per day from the age of twenty-three years until four years ago was recorded. Based upon his examination, Dr. Anderson fund pneumoconiosis to be present by chest x-ray. He found normal pulmonary function studies and symptoms of arteriosclerotic heart disease. In his opinion, the Claimant had an occupational lung disease, however, he was physically able, from a pulmonary standpoint, to perform his usual coal mine work. Dr. Anderson in board-certified in internal medicine and pulmonary disease.

Dr. Reams

Dr. Harold Reams, an audiologist, also examined Mr. Back in connection with his state claim. Dr. Reams stated that he saw the Claimant on July 9, 1992. A physical examination and testing revealed he had no hearing disability. DX 12.

Dr. Wicker

Dr. Mitchell Wicker examined the Claimant on behalf of the Department of Labor on July 18, 2001. DX 13. Dr. Wicker's qualifications are not in the record. Dr. Wicker recorded twenty or more years of coal mine employment and a smoking history of a few cigarettes per day for twenty years, the Claimant having stopped smoking in 1990. Based upon his examination, which included the taking of a chest x-ray, pulmonary function studies and blood gas testing, Dr

Wicker found no evidence of pneumoconiosis. In his opinion, the Claimant's respiratory capacity appeared to be adequate to perform his duties in the coal mining industry. He found no pulmonary impairment.

Dr. Lockey

Dr. James E. Lockey examined the Claimant on behalf of the Employer on August 23, 2001. DX 19. Dr. Lockey took histories and performed an examination which included the taking of a chest x-ray, blood gas test and pulmonary function studies. He recorded that the Claimant smoked less than a pack of cigarettes per month for sixteen years, quitting in 1986. Dr. Lockey estimated a one pack year history. Based upon his examination, Dr. Lockey opined that the Claimant did not have findings consistent with coal worker's pneumoconiosis. In addition, he found that the pulmonary function tests were completely within normal limits, as were the arterial blood gas determinations. From a pulmonary perspective, the Claimant was medically qualified to do his normal job tasks in the coal mining industry.

Dr. Lockey was deposed on January 11, 2002. DX 19. Dr. Lockey testified that he is board-certified in internal medicine, pulmonary medicine and occupational medicine. Dr. Lockey described his August 23, 2001, examination of the Claimant and recapitulated his findings. Dr. Lockey reiterated his opinion that the Claimant did not have findings consistent with coal worker's pneumoconiosis, and he retained the respiratory capacity to do his usual customary work duty responsibilities in and around the coal mining industry. Asked about Mr. Back's carbon monoxide level, Dr. Lockey said that at 6.8, it was elevated above what is normally associated with passive smoke exposure, but was normal for an active smoker.

Dr. Baker

Dr. Glen R. Baker, Jr., examined the Claimant at the request of his counsel on November 28, 2001. DX 16. He is board-certified in internal medicine and pulmonary disease, and a B-reader. Dr. Baker recorded twenty years of surface mining and ten years of cigarette smoking, at the rate of less than one pack per day, the Claimant having quit smoking fifteen to twenty years ago. Based upon his examination, which included the taking of a chest x-ray, pulmonary function testing and blood gas study, Dr. Baker diagnosed (1) pneumoconiosis, category 1/0 based on abnormal x-ray and significant history of dust exposure; (2) mild resting arterial hypoxemia, based on arterial blood gas analysis; and (3) chronic bronchitis, based on history. With regard to impairment, Dr. Baker found a Class I impairment with the FEV1 and vital capacity both being greater than 80% of predicted. He also found a second impairment based on the presence of pneumoconiosis, based on *Guides to the Evaluation of Permanent Impairment,* Fifth Edition, which states that persons who develop pneumoconiosis should limit further exposure to the offending agent. Dr. Baker opined that this would imply that the Claimant was 100% occupationally disabled for work in the coal mining industry or similar dusty occupations. Dr. Baker indicated that the disease was the result of exposure to coal dust, based on the x-ray and twenty year history of coal dust exposure. He also found any pulmonary impairment to be the result of exposure to coal dust, indicating that the Claimant had a less than ten pack year history of smoking and twenty years or more in the coal mining industry with x-ray evidence of pneumoconiosis.

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

> (a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.
>
> (1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.
>
> (2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.
>
> (c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 CFR § 718.201 (2003).

20 CFR § 718.202(a) (2003) provides that a finding of the existence of pneumoconiosis may be based on (1) chest x-ray, (2) biopsy or autopsy, (3) application of the presumptions described in Sections 718.304 (irrebuttable presumption of total disability due to pneumoconiosis if there is a showing of complicated pneumoconiosis), 718.305 (not applicable to claims filed after January 1, 1982) or 718.306 (applicable only to deceased miners), or (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. There is no evidence that Mr. Back has had a lung biopsy, and, of course, no autopsy has been performed. None of the presumptions apply, because the evidence does not establish the existence of complicated pneumoconiosis, Mr. Back filed his claim after January 1, 1982, and he is still living. In order to determine whether the evidence establishes the existence of pneumoconiosis, therefore, I must consider the chest x-rays and medical opinions. Absent contrary evidence, evidence relevant to either category may establish the existence of pneumoconiosis. In the face of conflicting evidence, however, I must weigh all of the evidence together in reaching my finding whether the Claimant has established that he has

pneumoconiosis. *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 211 (4th Cir. 2000); *Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22 (3rd Cir. 1997).

Pneumoconiosis is a progressive and irreversible disease. *Labelle Processing Co. v. Swarrow*, 72 F.3d 308, 314-315 (3rd Cir. 1995); *Lane Hollow Coal Co. v. Director, OWCP*, 137 F.3d 799, 803 (4th Cir. 1998); *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. See *Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151-152 (1987); *Eastern Associated Coal Corp. v. Director, OWCP*, 220 F.3d 250, 258-259 (4th Cir. 2000); *Crace v. Kentland-Elkhorn Coal Corp*., 109 F.3d 1163, 1167 (6th Cir. 1997); *Rochester & Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600, 602 (3rd Cir. 1989); *Stanford v. Director, OWCP*, 7 B.L.R. 1-541, 1-543 (1984); *Tokarcik v. Consolidated Coal Co*., 6 B.L.R. 1-666, 1-668 (1983); *Call v. Director, OWCP*, 2 B.L.R. 1-146, 1-148-1-149 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward*, 991 F.2d at 319-320; *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992); *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-600 (1984).

Of the five available x-rays in this case, two have been read only as positive, one has been read as positive and negative by different readers, and two have been read only as negative. For cases with conflicting x-ray evidence, the Regulations specifically provide,

> Where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays.

20 CFR § 718.202(a)(1); *Dixon v. North Camp Coal Co.*, 8 B.L.R. 1-344 (1985); *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31, 1-37 (1991). Readers who are board-certified radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n.5 (1985). Greater weight may be accorded to x-ray interpretations of dually qualified physicians. *Sheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128, 1-131 (1984). A judge may consider the number of interpretations on each side of the issue, but not to the exclusion of a qualitative evaluation of the x-rays and their readers. *Woodward*, 991 F.2d at 321; *see Adkins*, 958 F.2d at 52.

The chest x-ray taken on October 4, 1990 was read as positive by all three physicians who read it for pneumoconiosis, only one such reader, Dr. Lane, being a B-reader. Dr. Arlington Shotwell, apparently the radiologist who first interpreted the x-ray, diagnosed old granulomatous disease, but did not mention pneumoconiosis. Whether an x-ray interpretation which is **silent** as to pneumoconiosis should be interpreted as **negative** for pneumoconiosis, is an issue of fact for the ALJ to resolve. *Marra v. Consolidation Coal Co.*, 7 B.L.R. 1-216 (1984); *Sacolick v. Rushton Mining Co.*, 6 B.L.R. 1-930 (1984). I find his reading neither positive nor negative. As all of the other readings were positive, I find this x-ray to be positive.

The September 10, 1991 chest x-ray was read as positive by Dr. Anderson and negative by Dr. Harrison, a B-reader. I find this x-ray to be negative, based on Dr. Harrison's greater qualifications.

The July 18, 2001 and August 23, 2001, chest x-rays were found to be negative by three B-readers, one of whom, Dr. Wiot, is also a board-certified radiologist, while the November 28, 2001 chest x-ray was found to be positive by Dr. Baker, who is a B-reader. These three x-rays, taken within about four months of each other, are essentially contemporaneous. Based on the readings, I find the first two to be negative, and the last to be positive.

Of all of the readers of the recent x-rays, only Dr. Wiot is dually qualified. He read both the x-rays he reviewed as negative. Dr. Wiot was deposed on December 28, 2001. DX 18. He has been a member of the American College of Radiology task force on pneumoconiosis since 1968 and is the chairman of the program committee which trains B readers. He said lung markings of pneumoconiosis would be permanent and appear on every x-ray. He agreed that there are some disease entities which may mimic pneumoconiosis but produce only temporary findings.

To recapitulate, the two x-rays from 1990 and 1991 are diametrically opposed, one positive, and one negative. Of the more recent x-rays, two are negative, and one positive. The weight of the x-ray evidence overall is therefore negative. The more recent x-rays are entitled to greater weight. Additionally, Drs. Wiot, Wicker, and Lockey, all of whom are B-readers, found the x-rays they read to be negative. Dr. Baker is the only B-reader who found a recent x-ray to be positive. Moreover, the weight of the recent x-ray evidence is also negative. Given all of these factors, I find that the x-ray evidence fails to establish the existence of pneumoconiosis under Section 718.202(a)(1).

I must next consider the medical opinions. The Claimant can establish that he suffers from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co*., 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co*., 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields*, above. Whether a medical report is sufficiently documented and reasoned is for the judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co*., 12 B.L.R. 1-149, 1-155 (1989) (en banc).

The qualifications of the physicians are relevant in assessing the respective probative values to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-599 (1984). More weight may be accorded to the conclusions of a treating physician as he or she is more likely to be familiar with the miner's condition than a physician who examines him episodically. *Onderko v. Director, OWC*P, 14 B.L.R. 1-2, 1-6 (1989). However, in this case, I do not have opinions from any of Mr. Back's treating physicians.

In the instant case, Drs. Anderson, Wicker, Lockey and Baker submitted relevant medical reports. Dr. Anderson, in 1990, and Dr. Baker in 2001, found pneumoconiosis to be present by chest x-ray. Drs. Wicker and Lockey found the disease to be absent. The conflicting medical opinions must be weighed to resolve the contrary conclusions. All of the physicians who

provided medical opinions did so based on adequate underlying documentation. All provided at least some rationale in support of their conclusions. Thus I consider all of these medical opinions to represent documented and reasoned medical opinions.

After weighing all of the medical opinions of record, however, I resolve this conflict by according greater probative weight to the opinions of Drs. Lockey and Wicker. Dr. Lockey possesses excellent credentials in the field of pulmonary disease. Both had the opportunity to examine the Claimant. I also find their reasoning and explanation in support of their conclusions more complete and thorough than that provided by the physicians who concluded that the Claimant was suffering from pneumoconiosis. Drs. Wicker and Lockey better explained how all of the evidence they developed supported their conclusions. I also find their opinions to be in better accord both with the objective evidence and the overall weight of the medical evidence of record. Furthermore, Drs. Baker and Anderson appear to rely heavily upon their own positive readings of the chest x-rays they reviewed, while more highly qualified physicians found x-ray evidence to be negative for the disease.

In sum, I do not discredit any of the medical opinions of record. In resolving the conflict presented by the physicians of record, however, I find the opinions of Drs. Wicker and Lockey to merit greater probative weight. Their opinions therefore outweigh the contrary conclusions provided by Drs. Anderson and Baker. I conclude, therefore, that the Claimant has failed to establish that he has pneumoconiosis as the Act requires for entitlement to benefits.

Causal Relationship Between Pneumoconiosis and Coal Mine Employment

The Act and the regulations provide for a rebuttable presumption that pneumoconiosis arose out of coal mine employment if a miner with pneumoconiosis was employed in the mines for ten or more years. 30 U.S.C. § 921(c)(1); 20 CFR § 718.203(b) (2003). Mr. Back was employed as a miner for over 18 years, and therefore would be entitled to the presumption if he were found to have pneumoconiosis.

Total Disability

Even assuming, arguendo, that the existence of pneumoconiosis had been established, the Claimant would still not be entitled to benefits under the Act, as the evidence fails to establish total disability due to a pulmonary or respiratory impairment.

A miner is considered totally disabled if he has complicated pneumoconiosis, 30 U.S.C. § 921(c)(3), 20 CFR § 718.304 (2003), or if he has a pulmonary or respiratory impairment to which pneumoconiosis is a substantially contributing cause, and which prevents him from doing his usual coal mine employment and comparable gainful employment, 30 U.S.C. § 902(f), 20 CFR § 718.204(b) and (c) (2003). The Regulations provide five methods to show total disability other than by the presence of complicated pneumoconiosis: (1) pulmonary function studies; (2) blood gas studies; (3) evidence of cor pulmonale; (4) reasoned medical opinion; and (5) lay testimony. 20 CFR § 718.204(b) and (d) (2003). Lay testimony may only be used in establishing total disability in cases involving deceased miners, and in a living miner's claim, a finding of total disability due to pneumoconiosis cannot be made solely on the miner's statements or testimony. 20 CFR § 718.204(d) (2003); *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-106 (1994). There is no evidence in the record that Mr. Back suffers from complicated

pneumoconiosis or cor pulmonale. Thus I will consider pulmonary function studies, blood gas studies and medical opinions.

In the instant case, none of the pulmonary function and blood gas studies produced values indicative of total disability. Therefore, total disability cannot be established pursuant to 20 CFR § 718.204(b)(i) or (ii) (2003). Furthermore, of the physicians who examined the Claimant, Drs. Anderson, Lockey and Wicker found the Claimant not disabled. Dr. Baker finds disability based on the premise that a miner who develops pneumoconiosis should limit further exposure to coal mine dust. This, in and of itself, however, does not constitute a finding of disability pursuant to the regulations or case law. *See Zimmerman v. Director, OWCP*, 871 F2d 564, 567 (6th Cir. 1989). Of particular note, Dr. Baker has not said that Mr. Back could not do comparable work in a dust-free environment. When his and the other doctors' opinions are considered in conjunction with the results of the objective tests, I conclude that the Claimant has failed to establish that he is totally disabled by a pulmonary or respiratory impairment.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

Because the Claimant has failed to establish that he is suffering from pneumoconiosis or that he is totally disabled by a pulmonary or respiratory impairment, he is not entitled to benefits under the Act.

ATTORNEY FEES

The award of an attorney's fee under the Act is permitted only in cases in which the claimant is found to be entitled to benefits. Section 28 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 928, as incorporated into the Black Lung Benefits Act, 30 U.S.C. § 932. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for services rendered to him in pursuit of this claim.

ORDER

The claim for benefits filed by Ralph Back on June 7, 2001, is hereby DENIED.

A

Alice M. Craft
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 CFR § 725.481 (2003), any party dissatisfied with this decision and order may appeal it to the Benefits Review Board within 30 days from the date of this decision and order, by filing a notice of appeal with the Benefits Review Board at P.O. Box 37601, Washington, DC 20013-7601. A copy of a notice of appeal must also be served on Donald S. Shire, Esq. Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Ave., NW, Washington, D.C. 20210.